		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0024463

Facility Name: Peterson Park Health Care Center

Address: 6141 N. Pulaski (Number) Chicago (City) 60646 (Zip Code)

County: Cook

Telephone Number: (773) 478-2000 **Fax #** (773) 478-8408

IDPA ID Number: 36-2999153

Date of Initial License for Current Owners: 01/01/78

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Bob Kagda **Telephone Number:** (773) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Bob Kagda, Partner
(Firm Name & Address) Krupnick, Bokor, Kagda & Brooks, Ltd. 3750 W. Devon Ave. Lincolnwood, Il 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	33,945	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,675	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,831		5,216	9,047	8
9	SNF/PED					9
10	ICF	47,047	3,871		50,918	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,878	3,871	5,216	59,965	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.39%

D. How many bed-hold days during this year were paid by Public Aid?
854 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/78

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 17 and days of care provided 5,216

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	293,808	41,166	24,731	359,705		359,705		359,705			1
2	Food Purchase		337,666		337,666	(44,063)	293,603	(204)	293,399			2
3	Housekeeping	123,368	33,544		156,912		156,912		156,912			3
4	Laundry	67,599	8,909		76,508		76,508		76,508			4
5	Heat and Other Utilities			134,101	134,101		134,101	4,813	138,914			5
6	Maintenance	81,658		67,692	149,350		149,350	1,692	151,042			6
7	Other (specify):*											7
8	**TOTAL General Services**	566,433	421,285	226,524	1,214,242	(44,063)	1,170,179	6,301	1,176,480			8
	B. Health Care and Programs											
9	Medical Director			15,050	15,050		15,050		15,050			9
10	Nursing and Medical Records	2,174,223	124,287	33,655	2,332,165		2,332,165		2,332,165			10
10a	Therapy		586	21,201	21,787		21,787		21,787			10a
11	Activities	154,679	27,115	9,965	191,759		191,759		191,759			11
12	Social Services	251,264		8,080	259,344		259,344		259,344			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,580,166	151,988	87,951	2,820,105		2,820,105		2,820,105			16
	C. General Administration											
17	Administrative	149,985		539,285	689,270		689,270	(447,941)	241,329			17
18	Directors Fees											18
19	Professional Services			84,881	84,881	(24,000)	60,881	2,029	62,910			19
20	Dues, Fees, Subscriptions & Promotions			52,529	52,529		52,529	(26,201)	26,328			20
21	Clerical & General Office Expenses	107,754	36,653	204,710	349,117		349,117	35,161	384,278			21
22	Employee Benefits & Payroll Taxes			526,590	526,590	44,063	570,653	11,490	582,143			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,880	4,880		4,880	(200)	4,680			24
25	Other Admin. Staff Transportation			6,325	6,325		6,325	(3,851)	2,474			25
26	Insurance-Prop.Liab.Malpractice			150,933	150,933		150,933	2,662	153,595			26
27	Other (specify):*							2,957	2,957			27
28	**TOTAL General Administration**	257,739	36,653	1,570,133	1,864,525	20,063	1,884,588	(423,894)	1,460,694			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,404,338	609,926	1,884,608	5,898,872	(24,000)	5,874,872	(417,593)	5,457,279			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Peterson Park Health Care Center
0024463
COST REPORT RECLASSIFICATIONS
01/01/02
12/31/02

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	44,063	
2	FOOD		44,063

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	24,000	
19	PROFESSIONAL FEES		24,000

To reclass cost of appealing real estate taxes

Facility Name & ID Number Peterson Park Health Care Center #0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,200	128,200		128,200	90,980	219,180			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,963	70,963		70,963	78,408	149,371			32
33	Real Estate Taxes			152,549	152,549	24,000	176,549	87,777	264,326			33
34	Rent-Facility & Grounds			300,000	300,000		300,000	(300,000)				34
35	Rent-Equipment & Vehicles			1,195	1,195		1,195	4,542	5,737			35
36	Other (specify):* Mtge Costs							572	572			36
37	**TOTAL Ownership**			652,907	652,907	24,000	676,907	(37,721)	639,186			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	86,882	188,998	100,260	376,140		376,140		376,140			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	86,882	188,998	203,190	479,070		479,070		479,070			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,491,220	798,924	2,740,705	7,030,849		7,030,849	(455,314)	6,575,535			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,128	30		9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(204)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,945)	21		18
19	Entertainment				19
20	Contributions	(730)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,811)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,375)	21		24
25	Fund Raising, Advertising and Promotional	(23,308)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(65,030)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (190,290)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(265,024)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (265,024)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (455,314)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Peterson Park Health Care Center

ID# 0024463

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Ill Council LTC to COPE	$ (2,302)	20	1
2	Bank Charges	(55,052)	21	2
3	Marketing	(1,056)	19	3
4	Trust Fees	(300)	20	4
5	Auto Expense	(6,120)	25	5
6	Seminar -duplication	(200)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(65,030)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(204)	0	0	0	0	0	0	0	0	0	0	(204)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,813	0	0	0	0	0	0	0	0	4,813	5
6	Maintenance	0	0	1,692	0	0	0	0	0	0	0	0	1,692	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(204)	0	6,505	0	0	0	0	0	0	0	0	6,301	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	10,000	(433,305)	(24,636)	0	0	0	0	0	0	0	(447,941)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,867)	675	4,221	0	0	0	0	0	0	0	0	2,029	19
20	Fees, Subscriptions & Promotions	(26,640)	0	439	0	0	0	0	0	0	0	0	(26,201)	20
21	Clerical & General Office Expenses	(165,372)	1,645	198,888	0	0	0	0	0	0	0	0	35,161	21
22	Employee Benefits & Payroll Taxes	0	0	11,490	0	0	0	0	0	0	0	0	11,490	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(200)	0	0	0	0	0	0	0	0	0	0	(200)	24
25	Other Admin. Staff Transportation	(6,120)	0	2,269	0	0	0	0	0	0	0	0	(3,851)	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,662	0	0	0	0	0	0	0	0	2,662	26
27	Other (specify):*	0	0	0	2,957	0	0	0	0	0	0	0	2,957	27
28	**TOTAL General Administration**	(201,199)	12,320	(213,336)	(21,679)	0	0	0	0	0	0	0	(423,894)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(201,403)	12,320	(206,831)	(21,679)	0	0	0	0	0	0	0	(417,593)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	11,128	64,099	15,753	0	0	0	0	0	0	0	0	90,980	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15)	64,873	13,550	0	0	0	0	0	0	0	0	78,408	32
33	Real Estate Taxes	0	80,000	7,777	0	0	0	0	0	0	0	0	87,777	33
34	Rent-Facility & Grounds	0	(300,000)	0	0	0	0	0	0	0	0	0	(300,000)	34
35	Rent-Equipment & Vehicles	0	0	4,542	0	0	0	0	0	0	0	0	4,542	35
36	Other (specify):*	0	572	0	0	0	0	0	0	0	0	0	572	36
37	**TOTAL Ownership**	11,113	(90,456)	41,622	0	0	0	0	0	0	0	0	(37,721)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(190,290)	(78,136)	(165,209)	(21,679)	0	0	0	0	0	0	0	(455,314)	45

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		Courtyard Terrace (Endee)	Rockford			
		Embassy Care Cener	Willmington			
		Peterson Park Health Care	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 300,000	Peterson Park Realty		$	$ (300,000)	1
2	V	32	Interest Expense		Peterson Park Realty		71,125	71,125	2
3	V	32	Interest Income		Peterson Park Realty		(6,252)	(6,252)	3
4	V	30	Depreciation		Peterson Park Realty		64,099	64,099	4
5	V	21	Bank Charges		Peterson Park Realty		475	475	5
6	V	21	Trust Fees		Peterson Park Realty		1,170	1,170	6
7	V	17	Management Fees		Peterson Park Realty		10,000	10,000	7
8	V	36	Amort of Mtge Costs		Peterson Park Realty		572	572	8
9	V	19	Legal Fees		Peterson Park Realty		675	675	9
10	V	33	RE Tax Expense		Peterson Park Realty		80,000	80,000	10
11	V								11
12	V								12
13	V								13
14	Total			$ 300,000			$ 221,864	$ * (78,136)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 549,285	Future Associates		$	$ (549,285)	15
16	V	5	Utilities		Future Associates		4,813	4,813	16
17	V	6	Maintenance		Future Associates		1,692	1,692	17
18	V	17	Administrative		Future Associates		115,980	115,980	18
19	V	19	Professional Fees		Future Associates		4,221	4,221	19
20	V	21	Clerical and General		Future Associates		198,888	198,888	20
21	V	22	Employee Benefits		Future Associates		11,490	11,490	21
22	V	25	Auto Expense		Future Associates		2,269	2,269	22
23	V	26	Insurance Expense		Future Associates		2,662	2,662	23
24	V	30	Depreciation		Future Associates		15,753	15,753	24
25	V	32	Interest Expense		Future Associates		13,550	13,550	25
26	V	33	Real Estate Taxes		Future Associates		7,777	7,777	26
27	V	35	Equipment Rental		Future Associates		4,542	4,542	27
28	V	20	License, Dues, Fees		Future Associates		439	439	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 549,285			$ 384,076	$ * (165,209)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	Salary Ron Shabat	$	Shabat & Associates	100.00%	$ 86,364	$ 86,364	15
16	V		27	Payroll Taxes		Shabat & Associates	100.00%	2,957	2,957	16
17	V		17	Management Fees (from Future)	111,000				(111,000)	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 111,000			$ 89,321	$ * (21,679)	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Ronald Shabat	Director	Administrative	43.09		25	50.00	Salary	$ 39,000	17-1	1
2	Ronald Shabat	Director	Administrative	43.09		25	50.00	Allocated	86,364	17-7	2
3	Haim Perlstein	Director	Administrative	0.00		3	5.00	Allocated	4,980	17-7	3
4	Menachem Shabat	Administrator	Administrative	6.38		60	100.00	Salary	67,904	17-1	4
5	Nachshon Draiman	Director	Administrative	35.64							5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 198,248		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Future Associates
Street Address: 7514 N. Skokie Blvd
City / State / Zip Code: Skokie, Il
Phone Number: (847)982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Management Fees	1,088,122	4	$ 9,622	$	544,285	$ 4,813	1
2	6	Maintenance	Management Fees	1,088,122	4	3,382		544,285	1,692	2
3	17	Administrative	Direct allocation		4	210,600		115,980	115,980	3
4	19	Professional Fees	Management Fees	1,088,122	4	8,439		544,285	4,221	4
5	21	Clerical and General	Management Fees	1,088,122	4	348,350	280,707	544,285	174,247	5
6	22	Employee Benefits	Management Fees	1,088,122	4	19,004		544,285	9,506	6
7	25	Auto Expense	Management Fees	1,088,122	4	4,537		544,285	2,269	7
8	26	Insurance Expense	Management Fees	1,088,122	4	5,322		544,285	2,662	8
9	30	Depreciation	Management Fees	1,088,122	4	31,490		544,285	15,751	9
10	32	Interest Expense	Management Fees	1,088,122	4	27,089		544,285	13,550	10
11	33	Real Estate Taxes	Management Fees	1,088,122	4	15,548		544,285	7,777	11
12	35	Equipment Rental	Management Fees	1,088,122	4	9,080		544,285	4,542	12
13	20	License, Dues, Fees	Management Fees	1,088,122	4	877		544,285	439	13
14	21	Clerical and General	Direct allocation		4	44,804	44,804		24,642	14
15	22	Employee Benefits	Direct allocation		4	3,608			1,984	15
16	10	Nursing Costs	Direct allocation		1	60,000				16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 801,752	$ 325,511		$ 384,075	25

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Shabat & Associates
Street Address: 7514 N Skokie Blvd
City / State / Zip Code: Chicago, Il 60077
Phone Number: (847)-982-1195
Fax Number: (847)982-0992

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salary R Shabat	Avge Hrs Wkd	55	3	$ 190,000	$ 190,000	25	$ 86,364	1
2	27	Payroll Taxes	Avge Hrs Wkd	55	3	6,508		25	2,958	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 196,508	$ 190,000		$ 89,322	25

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BankFinancial, F.S.B.		X	Mortgage	$35,075.41	8/20/02	$ 6,000,000	$ 5,965,898	9/01/07	Var	$ 71,125	1
2	Minolta Copier		X	Equipment Purchase		01/2000	21,285				284	2
3												3
4	Allocation from Future	X									13,550	4
5												5
	Working Capital											
6	Bank Financial		X	Line of Credit		Various		798,411			50,783	6
7	Insurance		X								3,371	7
8	Illinois Provider Asses		X								6,457	8
9	TOTAL Facility Related				$35,075.41		$ 6,021,285	$ 6,764,309			$ 145,570	9
	B. Non-Facility Related*											
10	Interest Income		x								(15)	10
11	Interest Income Realty		x								(6,252)	11
12	Real Estate Taxes		x								10,068	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 3,801	14
15	TOTALS (line 9+line14)						$ 6,021,285	$ 6,764,309			$ 149,371	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 0	$ 0			$ 0	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 0	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 237,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 237,326	2
3. Under or (over) accrual (line 2 minus line 1).		$ 326	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 240,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 24,000	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 264,326	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	286,611	8
	1998	291,699	9
	1999	230,523	10
	2000	223,731	11
	2001	229,549	12
Estimate based on 2001 bill		240000	
Allocation from Future		7777	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Peterson Park Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0024463

CONTACT PERSON REGARDING THIS REPORT Bob Kagda

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-02-115-052-0000	Facility	$ 229,549.00	$ 229,549.00
2.	10-28-408-025	Management Office	$ 17,878.19	$ 2,541.00
3.	10-28-408-026	Management Office	$ 8,732.66	$ 1,241.00
4.	10-28-408-027	Management Office	$ 8,732.66	$ 1,241.00
5.	10-28-408-028	Management Office	$ 12,675.01	$ 1,801.00
6.	10-28-408-029	Management Office	$ 12,675.01	$ 1,801.00
7.	10-28-408-030	Management Office	$ 1,518.93	$ 216.00
8.	10-28-408-031	Management Office	$ 1,518.93	$ 216.00
9.			$	$
10.			$	$
		TOTALS	$ 293,280.39	$ 238,606.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,900 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1986	$ 283,071	1
2					2
3	TOTALS			$ 283,071	3

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	188		1986		$ 2,548,850	$ 107,052	35	$ 72,824	$ (34,228)	$ 1,171,253	4
5	Alloc LCF		1986		108,714	4,566	30	3,624	(942)	58,283	5
6	Alloc LCF		1987		2,608	83	31.5	83		1,284	6
7											7
8											8
	Improvement Type**										
9	Various			1979	4,800		6			4,800	9
10	Various			1981	57,728		8	49	49	57,728	10
11	Various			1982	11,967		7			11,967	11
12	Various			1983	3,440		5			3,440	12
13	Various			1984	12,700		15	312	312	12,700	13
14	Various			1985	98,707		19	1,477	1,477	96,369	14
15	Various			1986	42,087	239	19	2,214	1,975	36,668	15
16	Various			1987	17,729	563	31	572	9	9,014	16
17	Various			1988	35,577	1,129	31	1,148	19	16,437	17
18	Various			1989	14,591	463	31	471	8	6,297	18
19	Various			1990	27,693	879	31	893	14	11,075	19
20	Various			1991	62,352	1,980	20	3,118	1,138	35,110	20
21	Various			1992	10,152	322	20	508	186	5,588	21
22	Various			1993	21,815	247	20	1,092	845	10,492	22
23	Various			1994	264,384	5,874	20	13,222	7,348	109,218	23
24	Various			1995	110,992	2,753	20	5,550	2,797	41,385	24
25	Various			1996	35,086	955	20	1,757	802	11,535	25
26	Various			1997	62,950	1,614	20	3,149	1,535	17,010	26
27	Various			1998	49,698	1,274	20	2,487	1,213	11,739	27
28	OUTLETS WIRING			1/1/1999	733	19	20	37	18	148	28
29	220V FOR FREEZER			1/12/1999	500	13	20	25	12	100	29
30	Circular Pump			1/28/1999	4,738	121	20	237	116	948	30
31	Door hinges			2/4/1999	1,402	36	20	70	34	274	31
32	WALLPAPER			2/11/1999	1,535	39	20	77	38	302	32
33	WALLPAPER			2/15/1999	1,475	38	20	74	36	290	33
34	FIRE ALARM PANELS			3/1/1999	1,408	36	20	70	34	268	34
35	FAUCETS			3/29/1999	1,941	50	20	97	47	372	35
36	KITCHEN EXHAUST			5/6/1999	999	26	20	50	24	183	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	EJECTOR PUMP	5/11/1999	$ 5,571	$ 143	20	$ 279	$ 136	$ 1,023	37
38	NEW SOLENOID KIT	5/13/1999	390	10	20	20	10	73	38
39	THRESHOLD KITCHEN	5/17/1999	1,433	37	20	72	35	264	39
40	NEW PIPE - HEATER	5/25/1999	249	6	20	12	6	44	40
41	ARCHITECT-REMODEL	5/28/1999	1,700	44	20	85	41	312	41
42	KITCHEN IMPROVEMENTS	6/2/1999	3,037	78	20	152	74	545	42
43	KITCHEN EXHAUST	6/8/1999	511	13	20	26	13	93	43
44	CUBICLE CURTAINS	6/8/1999	1,261	32	20	63	31	226	44
45	WALL AIR CONDI.	6/8/1999	3,586	92	20	179	87	641	45
46	ROOF REPAIRS	6/9/1999	5,240	134	20	262	128	939	46
47	NEW DOORS	6/15/1999	6,765	173	20	338	165	1,211	47
48	NEW SINKS	6/17/1999	2,500	64	20	125	61	448	48
49	FRONT DOORS-THRESHLD	6/25/1999	1,421	36	20	71	35	254	49
50	ELECTRIC UPGRADE	6/28/1999	5,350	137	20	268	131	960	50
51	HINGES HANGER ETC	7/22/1999	1,697	44	20	85	41	298	51
52	WALL AIR COND	7/26/1999	2,344	60	20	117	57	410	52
53	WALL AIR COND	7/29/1999	2,962	76	20	148	72	518	53
54	ROD OUT SEWER	8/10/1999	625	16	20	31	15	106	54
55	EXIT DOOR ALARM	8/12/1999	700	18	20	35	17	120	55
56	CORNICES	8/12/1999	20,381	523	20	1,019	496	3,482	56
57	SEWER WORK	8/19/1999	3,395	87	20	170	83	581	57
58	WINDOW WELL COVERS	9/13/1999	1,646	42	20	82	40	273	58
59	CUBICLE CURTAINS	9/16/1999	1,237	32	20	62	30	207	59
60	KITCHEN FAUCETS	9/30/1999	1,081	28	20	54	26	180	60
61	TANK PATCH	10/6/1999	1,167	30	20	58	28	189	61
62	FRONT CANOPY	10/28/1999	2,350	60	20	118	58	384	62
63	PULL HANDLE DOORS	11/2/1999	1,014	26	20	51	25	162	63
64	KITCHEN & lAB FAUCTS	11/9/1999	767	20	20	38	18	120	64
65	ELECTRIC OUTLETS	11/15/1999	1,710	44	20	86	42	272	65
66	Dual pres. control	1/31/2000	703	18	20	35	17	105	66
67	Rehung Door closers	1/31/2000	1,183	30	20	59	29	177	67
68	Det Heat 194F	1/31/2000	1,121	29	20	56	27	168	68
69	Enviormnt testing	2/28/2000	1,445	37	20	72	35	210	69
70	TOTAL (lines 4 thru 69)		$ 3,705,893	$ 132,590		$ 119,615	$ (12,975)	$ 1,757,272	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,705,893	$ 132,590		$ 119,615	$ (12,975)	$ 1,757,272	1
2	1 inch Valves	2/28/2000	556	14	20	28	14	82	2
3	Door Hldr Ball bear	3/31/2000	1,130	29	20	57	28	162	3
4	Valves ovrhd pipe	3/31/2000	1,997	51	20	100	49	283	4
5	3 grease traps	3/31/2000	7,345	188	20	367	179	1,040	5
6	Repair oven doors	3/31/2000	691	18	20	35	17	99	6
7	Fire suppression sys	4/30/2000	2,058	53	20	103	50	283	7
8	A/C thermostadt	4/30/2000	4,604	118	20	230	112	633	8
9	Repair rehang door	4/30/2000	1,578	40	20	79	39	217	9
10	Air conditioneers	5/31/2000	3,646	93	20	182	89	485	10
11	SS Panel	6/6/2000	372	10	20	19	9	49	11
12	New gas line	6/11/2000	875	22	20	44	22	114	12
13	Light fixtures	6/27/2000	22,067	566	20	1,103	537	2,849	13
14	Flooring Wallcover	6/27/2000	63,063	1,617	20	3,153	1,536	8,145	14
15	Repair doors	6/30/2000	2,184	56	20	109	53	282	15
16	New Ceiling Fixture	7/1/2000	6,205	159	20	310	151	775	16
17	Door closers	7/31/2000	1,435	37	20	72	35	180	17
18	Air conditioneers	8/31/2000	4,311	111	20	216	105	522	18
19	Vinyl floor tile	8/31/2000	566	15	20	28	13	68	19
20	New elect pipe wire	8/31/2000	1,300	33	20	65	32	157	20
21	Repair A/C lines	8/31/2000	2,804	72	20	140	68	338	21
22	Templer sprink.syst	8/31/2000	1,609	41	20	80	39	193	22
23	Install door frames	9/9/2000	4,150	106	20	208	102	485	23
24	Ceiling Dining room	9/26/2000	20,041	514	20	1,002	488	2,338	24
25	Rebult lift assemb	9/30/2000	557	14	20	28	14	65	25
26	Repair dining door	9/30/2000	481	12	20	24	12	56	26
27	Replace shower fauct	10/30/2000	2,800	72	20	140	68	315	27
28	Wallpaper	10/30/2000	683	18	20	34	16	77	28
29	Lobby baseboard	10/31/2000	1,437	37	20	72	35	162	29
30	New ceilings	10/31/2000	11,027	283	20	551	268	1,302	30
31	Wall - Employee DR	11/2/2000	2,411	62	20	121	59	262	31
32	Door closures	11/30/2000	1,213	31	20	61	30	132	32
33	Kitchen exhaust fan	11/30/2000	772	20	20	39	19	85	33
34	TOTAL (lines 1 thru 33)		$ 3,881,861	$ 137,102		$ 128,415	$ (8,687)	$ 1,779,507	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,881,861	$ 137,102		$ 128,415	$ (8,687)	$ 1,779,507	1
2	Probes for tank	12/31/2000	567	15	20	28	13	58	2
3	Borders Resident rm	12/31/2000	7,600	195	20	380	185	792	3
4	Borders resident rm	12/31/2000	637	16	20	32	16	67	4
5	WALLPAPER	1/1/2001	7,508	193	20	375	182	750	5
6	WATER HEATER	1/4/2001	5,240	134	20	262	128	524	6
7	HOT WATER HTR	1/12/2001	1,100	28	20	55	27	110	7
8	Floor tile	2/13/2001	2,290	59	20	115	56	220	8
9	Wallcoverings	2/27/2001	3,160	81	20	158	77	303	9
10	KEY & CYLINDERS	3/6/2001	1,348	35	20	67	32	123	10
11	WALLCOVERINGS	3/19/2001	11,626	298	20	581	283	1,065	11
12	VALVES PUMP A/C	3/22/2001	1,218	31	20	61	30	112	12
13	TILES	3/26/2001	1,788	46	20	89	43	163	13
14	BATH TUB FAUCETS	4/3/2001	3,450	88	20	173	85	303	14
15	DOOR CLOSE	4/4/2001	607	16	20	30	14	53	15
16	WINDOW TREATMENT	4/11/2001	1,536	39	20	77	38	135	16
17	HANDLE STOPPER	4/16/2001	625	16	20	31	15	54	17
18	ALARM CONTROL	5/25/2001	1,880	48	20	94	46	157	18
19	NEW LAV FAUCETS	5/29/2001	625	16	20	31	15	52	19
20	BROKEN SEWER LINE	6/5/2001	1,400	36	20	70	34	111	20
21	AIR COND	6/11/2001	3,743	96	20	187	91	296	21
22	AIR COND	6/14/2001	3,027	78	20	151	73	239	22
23	AIR COND	6/29/2001	3,324	85	20	166	81	263	23
24	WALKWAY RETAIN WALL	7/5/2001	2,590	66	20	130	64	195	24
25	CCTV system repair	8/10/2001	2,967	76	20	148	72	210	25
26	CCTV repairs	8/29/2001	952	24	20	48	24	68	26
27	Tile	9/14/2001	513	13	20	26	13	35	27
28	Roofing	9/19/2001	895	23	20	45	22	60	28
29	CCTV-reception desk	10/15/2001	1,560	40	20	78	38	98	29
30	Repair 6inc.sew.line	11/13/2001	1,250	32	20	63	31	74	30
31	STOREROOM LOCK	11/16/2001	937	24	20	47	23	55	31
32	PILOT SAFETY CONTROL	12/6/2001	1,514	39	20	76	37	82	32
33	ENERGY MGMT CONTROL	12/6/2001	1,975	51	20	99	48	107	33
34	TOTAL (lines 1 thru 33)		$ 3,961,313	$ 139,139		$ 132,388	$ (6,751)	$ 1,786,441	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,961,313	$ 139,139		$ 132,388	$ (6,751)	$ 1,786,441	1
2	REPAIR NSE CALL SYS	12/14/2001	715	18	20	36	18	39	2
3	EXHAUST FAN	12/20/2001	1,675	43	20	84	41	91	3
4	NEW ROOFTOP KIT. FAN	12/24/2001	880	23	20	44	21	48	4
5	Electric line and outlets	1/16/2002	3,380	83	20	155	72	155	5
6	Nurse call system	2/15/2002	767	17	20	35	18	35	6
7	Solenoid lock w/ magnet	2/15/2002	885	20	20	41	21	41	7
8	Nurs call system 2 south	3/25/2002	728	15	20	27	12	27	8
9	Nurs call system 1 north	3/25/2002	741	15	20	28	13	28	9
10	Remove old ceiling	5/8/2002	82,615	1,324	20	2,754	1,430	2,754	10
11	Exhaust Fan	5/13/2002	1,875	30	20	63	33	63	11
12	7 Air conditioneers	5/13/2002	4,485	72	20	150	78	150	12
13	Exhaust Fan	5/14/2002	3,865	62	20	129	67	129	13
14	Plastic anchors	5/28/2002	1,098	18	20	32	14	32	14
15	Nurse station	5/30/2002	53,692	860	20	1,566	706	1,566	15
16	New stainless steel sdink	6/3/2002	540	8	20	16	8	16	16
17	New crown moldings dayrooms	6/3/2002	4,170	58	20	122	64	122	17
18	Remove install handrail bumpers	6/12/2002	6,060	84	20	177	93	177	18
19	Repair 2 broken floor drains	6/12/2002	550	8	20	16	8	16	19
20	Window and new light	6/14/2002	808	11	20	24	13	24	20
21	Remove install floor d/r	6/17/2002	22,784	316	20	570	254	570	21
22	Front door alarm	6/19/2002	1,114	15	20	28	13	28	22
23	Wall covering	6/20/2002	55,100	765	20	1,378	613	1,378	23
24	Remove and install d/r lighting	6/20/2002	43,005	597	20	1,075	478	1,075	24
25	Paint remove walls paint wall coverings	6/20/2002	1,488	21	20	37	16	37	25
26	Modified bitumen roof install	7/2/2002	1,100	13	20	28	15	28	26
27	Handrails, bumpers & soffits	7/12/2002	9,031	106	20	226	120	226	27
28	Room signage, end caps window trtmnt	8/2/2002	5,023	48	20	105	57	105	28
29	Install 8inch+D29 inline duct fan	8/9/2002	875	8	20	18	10	18	29
30	PA System	8/12/2002	2,939	28	20	61	33	61	30
31	Architect per retainer	8/31/2002	3,000	29	20	50	21	50	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,276,301	$ 143,854		$ 141,463	$ (2,391)	$ 1,795,530	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,276,301	$ 143,854		$ 141,463	$ (2,391)	$ 1,795,530	1
2	Architect -Remodeling and addition	09/08/02	970	7	20	24	17	24	2
3	Modified bitumen roof install	09/20/02	1,480	11	20	37	26	37	3
4	Paint Moldings	09/27/02	700	5	20	18	13	18	4
5	Install security hardware	10/02/02	545	3	20	14	11	14	5
6	CCTV System 1 north day room	10/28/02	1,037	6	20	26	20	26	6
7	CCTV System 1 south D/R	10/28/02	1,037	6	20	26	20	26	7
8	Install latching alarm system	10/28/02	1,266	7	20	32	25	32	8
9	Rebuild And clean bathroom exhaust fans	10/31/02	1,225	7	20	31	24	31	9
10	2 new firex smoke alarms/detectors	11/13/02	1,755	6	20	44	38	44	10
11	CCTV System 2nd Floor South D/R	12/10/02	1,137	1	20	28	27	28	11
12	CCTV System 2nd Floor North D/R	12/10/02	1,137	1	20	28	27	28	12
13	Ceramic wall tile	12/11/02	4,801	5	20	120	115	120	13
14	Fire rated exit device	12/11/02	4,281	5	20	107	102	107	14
15	Window treatments	12/20/02	10,010	11	20	250	239	250	15
16	15 bathroom remodeling	12/23/02	7,000	7	20	175	168	175	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,314,682	$ 143,942		$ 142,423	$ (1,519)	$ 1,796,490	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,314,682	$ 143,942		$ 142,423	$ (1,519)	$ 1,796,490	1
2	Allocation from LCF	1987	14,962	475	31.5	475		7,243	2
3	Allocation from LCF	1988	840	27	31.5	27		383	3
4	Allocation from LCF	1989	313	10	39	10		132	4
5	Allocation from LCF	1993	8,691	223	39	223		2,087	5
6	Allocation from LCF	1994	13,252	340	39	340		2,872	6
7	Allocation from LCF-Air Cond; Roof repairs	2001	3,691	95	39	95		141	7
8	Allocation from LCF - 5 ton Trane A/C	2002	904	9	39	9		9	8
9									9
10	Allocation from Future	1987	47,153	1,497	31.5	1,521	24	24,164	10
11	Allocation from Future	1994	13,791	187	Var	837	650	7,436	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,418,279	$ 146,805		$ 145,960	$ (845)	$ 1,840,957	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 602,282	$ 49,594	$ 64,483	$ 14,889	10	$ 351,149	71
72	Current Year Purchases	49,004	8,347	3,419	(4,928)	10	3,419	72
73	Fully Depreciated Assets	450,164		2,012	2,012	10	450,164	73
74								74
75	TOTALS	$ 1,101,450	$ 57,941	$ 69,914	$ 11,973		$ 804,732	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocation from Future Assoc			$ 93,636	$ 3,306	$ 3,306	$	5	$ 55,584	76
77										77
78										78
79										79
80	TOTALS			$ 93,636	$ 3,306	$ 3,306	$		$ 55,584	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,896,436	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 208,052	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 219,180	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 11,128	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,701,273	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,195 Description: Pitney Bowes Meter Rental
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation from Future		$	$ 4,542	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,542	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1;39-3	hrs	$ 35,198		$ 12,210	$		$ 47,408	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,385			14,385	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1;39-3	hrs	51,684		39,993			91,677	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				132,864		132,864	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-2;39-3				33,672	56,134		89,806	13
14	TOTAL			$ 86,882		$ 100,260	$ 188,998		$ 376,140	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

PETERSON PARK HEALTH CARE CENTER 0024463 01/01/02 to 12/31/02
Page16 Supplemnt

Special Services - Supplies - (Column 6 -Other)

1	Med Tube : Ent., & Urol	39-2	22504
2	Equipment Rental	39-2	33630
	Total		56134

Outside Therapies (Column 5- Other)

1	Respiratory Therapy	39-3	21944
2	Lab & XRay	39-3	11728
	Total		33672

Facility Name & ID Number Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 452	$ 159,920	1
2	Cash-Patient Deposits	88,922	88,922	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 200,000)	1,226,557	1,226,713	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	90,330	90,330	6
7	Other Prepaid Expenses	1,354	1,354	7
8	Accounts Receivable (owners or related parties)	1,743,370	4,932,919	8
9	Other(specify):	14,835	117,151	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,165,820	$ 6,617,309	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		102,484	13
14	Buildings, at Historical Cost		2,548,850	14
15	Leasehold Improvements, at Historical Cost		1,495,970	15
16	Equipment, at Historical Cost		1,169,943	16
17	Accumulated Depreciation (book methods)		(3,608,953)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	5,902	62,553	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,902	$ 1,770,847	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,171,722	$ 8,388,156	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 800,814	$ 800,814	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	84,091	84,091	28
29	Short-Term Notes Payable	798,411	798,411	29
30	Accrued Salaries Payable	456,182	456,182	30
31	Accrued Taxes Payable (excluding real estate taxes)	46,062	46,062	31
32	Accrued Real Estate Taxes(Sch.IX-B)	160,000	240,000	32
33	Accrued Interest Payable	2,592	2,592	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Schedule attached			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,348,152	$ 2,428,152	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,965,898	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Schedule attached			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,965,898	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,348,152	$ 8,394,050	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 823,570	$ (5,894)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,171,722	$ 8,388,156	48

***(See instructions.)**

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES As of 12/31/02

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		102,316
Employee Advances	14,835	14,835
	14,835	117,151

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses		

OTHER NON CURRENT ASSETS:		
Construction In Progress		
Utility Deposit		
Mortgage Costs - Net		56,651
Exchange	5,902	5,902
	5,902	62,553

OTHER NON CURRENT LIABILITIES:	Amount	Amount

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 40,929	1
2	Restatements (describe):		2
3	**Correct Prior Year Distributions**	(18,800)	3
4	**Round Off Adj**	(2)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 22,127	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	876,643	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(75,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 801,443	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 823,570	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	Peterson Park Health Care Center	#	0024463	Report Period Beginning:	01/01/02	Ending:	12/31/02

Balance per General Ledger		
Adjustments:		
		-
		-
		-
Round Off Adj		
Total adjustments		-
Balance - Beginning of Year		-
Equity(Deficit) from Page 17 Col 1		823,570
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		823,570

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,206,198	1
2	Discounts and Allowances for all Levels	(119,515)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,086,683	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	554,904	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 554,904	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	92,204	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	25,462	20
21	Other Medical Services	87,028	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 204,694	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Schedule attached (Pg19_Supp)	61,196	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,196	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,907,492	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,214,242	31
32	Health Care	2,820,105	32
33	General Administration	1,864,525	33
	B. Capital Expense		
34	Ownership	652,907	34
	C. Ancillary Expense		
35	Special Cost Centers	376,140	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,030,849	40
41	**Income before Income Taxes (line 30 minus line 40)****	876,643	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 876,643	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/02

	DESCRIPTION			AMOUNT
1	Vending Commissions			
2	Adj of Prior period Expenses:			
3	Accounting	KBKB	15,750	
4	Accounting	FRR	22,016	
5	Void old checks prior to 2001		6,098	
6	Adjust A/P		(90)	
7	Adjust Rehab		(8,821)	
8	Adjust Class Advert		1,120	
9	Adjust PPS		1,864	
10	Adjust Drugs		2,945	
11	Adjust Security		2,430	
12	Adjust Water		10,831	
13	Adjust Therapy Cons		873	
14	Adjust DOL labor liability		6,180	61,196
15				
16				
17				
18				
19				
20				
		TOTALS		61,196

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,129	2,298	$ 87,549	$ 38.10	1
2	Assistant Director of Nursing	528	573	14,313	24.98	2
3	Registered Nurses	30,897	35,428	879,321	24.82	3
4	Licensed Practical Nurses	8,152	9,709	178,743	18.41	4
5	Nurse Aides & Orderlies	99,244	108,817	982,621	9.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	14,733	16,420	154,679	9.42	10
11	Social Service Workers	16,951	18,475	251,264	13.60	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,433	26,143	293,408	11.22	15
16	Dishwashers					16
17	Maintenance Workers	7,083	7,874	81,658	10.37	17
18	Housekeepers	14,207	15,776	123,368	7.82	18
19	Laundry	6,265	7,372	67,599	9.17	19
20	Administrator	5,186	5,469	149,985	27.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,435	9,950	107,754	10.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,677	1,746	31,676	18.14	31
32	Other Health Care(specify)	2,822	2,965	86,882	29.30	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	241,742	269,015	$ 3,490,820 *	$ 12.98	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	508	$ 20,783	1-3	35
36	Medical Director	Monthly	15,050	9-3	36
37	Medical Records Consultant	96	5,370	10-3	37
38	Nurse Consultant	119	11,721	10-3	38
39	Pharmacist Consultant	Monthly	4,104	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	149	21,201	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	95	4,180	11-3	44
45	Social Service Consultant	167	8,080	12-3	45
46	Other(specify) Rehab	218	12,460	10-3	46
47	Purchasing Cons	Monthly	3,948	1-3	47
48	Rerligious Cons	As Required	5,785	11-3	48
49	TOTAL (lines 35 - 48)	1,352	$ 112,682		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
PT Salaries	1,628	1,747	$ 51,684	$ 29.58
OT Salaries	1,194	1,218	35,198	28.90
	2,822	2,965	$ 86,882	$ 29.30

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ronald Shabat	Admin		$ 39,000
Charlene Wells	Admin	0	53,033
Menachem Shabat	Admin		67,904
Year End Accrual Adjustments			(9,952)
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 149,985

B. Administrative - Other

Description	Amount
Future Associates	$ 539,285
TOTAL (agree to Schedule V, line 17, col. 3)	$ 539,285
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LJ Cohn	Acctg	$ 17,708
R Peelo	Medicare Acctg	2,100
KBKB	Acctg	16,200
FR&R	Acctg	1,505
A&S Consulting	Employee recruitment	4,500
SVET	Mktg	1,056
Personnel Planners	UC Consulting	1,350
Pollack & Weiss	Legal	24,000
Sachnoff & Weaver	Legal	2,411
Micahel Best	Legal	7,789
Schedule attached		6,262
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 84,881

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,070
Unemployment Compensation Insurance	22,915
FICA Taxes	267,018
Employee Health Insurance	70,154
Employee Meals	44,063
Illinois Municipal Retirement Fund (IMRF)*	
Chicago City Head Tax	8,134
Health & Welfare Fund	58,176
Holiday Expense	4,905
Employee Life Insuarance	16,931
Employee Education	8,287
Alloc from Future	12,129
TOTAL (agree to Schedule V, line 22, col.8)	$ 582,782

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,039
Health Care Worker Background Check	
(Indicate # of checks performed 255)	3,068
Ill Council LTC	11,280
Licenses & Fees	2,804
Advertising	23,308
Donations	730
Trust Fee	300
Allocation from Future	460
Less: Public Relations Expense	( )
Non-allowable advertising	(26,640)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,349

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,880
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,880

* Attach copy of IMRF notifications

**See instructions.

Peterson Park Health Care Center **0024463**

01/01/02 to **12/31/02**

Page 21- Professional Services:

Vendor	Type	
Guardianship Services		1,912
Worldwide H/C	Recruitment Fees	3,920
U S Dept of Justice	Legal	270
M Schultz	Legal	160
		6,262

Facility Name & ID Number Peterson Park Health Care Center # 0024463 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Peterson Park Health Care Center # 0024463 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? Yes

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council Long Term Care--11280

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 16,355 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? No YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 102,930
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 44,063 Has any meal income been offset against related costs? No Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ No

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.